amount of the payment received under the policy, or to that portion of the total payment received which was designated for medical expenses. Based upon the results of the investigation described in paragraph (e)(3)(ii) of this section, the fiscal intermediary will segregate all claims involving treatment of personal injuries for which it is likely that such other insurance is available. These claims will be processed initially as double coverage claims under the provisions of §199.8 of this part. Any CHAMPUS payments made after the double coverage provisions have been fully complied with will be considered for possible third-party liability recovery under the provisions of this section.

(g) *Worker's Compensation Claims.* Based upon the results of the investigation described in paragraph (e)(3)(ii) of this section, the fiscal intermediary will segregate all claims involving treatment of work-related injuries. These claims will be processed initially as double coverage claims under §199.8 of this part dealing with worker's compensation claims. Any CHAMPUS payments made after the double coverage provisions have been fully complied with will be considered for possible third-party liability recovery under the provisions of this section. Unless all or a portion of a payment made pursuant to a worker's compensation claim is designated as reimbursement for medical expenses or for some other policy benefit, the full amount of all such undesignated payments shall be deemed to be for medical expenses incurred by the policy beneficiary.

(h) *Mixed claims.* Occasionally, a claim arising under the Medical Care Recovery Act will be referred to a claims collection authority which also has some other potential for recovery. A typical example of such a claim is one arising as the result of an automobile accident in which there is a likely tortfeasor and the injured party is also covered by some combination of other health insurance which is primary to CHAMPUS, such as, worker's compensation, or a medical payments provision of an automobile policy. These claims will also initially be processed as double coverage claims. In addition, agency claims collection authorities should take full cognizance of all avenues of potential recovery as long as there is any potential for recovery from the tortfeasor. Once final action has been taken, any remaining possible recovery under the Federal Claims Collection Act may be referred to the General Counsel, OCHAMPUS, for further action in accordance with §199.11 of this part. Such referrals should contain a complete report of all actions taken on the case and full and complete documentation of the claims involved.

§199.13 Active duty dependents dental plan.

(a) *General provisions*—(1) *Purpose.* This section prescribes guidelines and policies for the delivery and administration of the Active Duty Dependents Dental Plan of the Uniformed Services for the Army, the Navy, the Air Force, the Marine Corps, the Coast Guard, the Commissioned Corps of the U.S. Public Health Service (USPHS), and the Commissioned Corps of the National Oceanic and Atmospheric Administration (NOAA).

(2) *Applicability*—(i) *Geographic.* This section is applicable geographically within the 50 States of the United States, the District of Columbia, the Commonwealth of Puerto Rico, Guam, and the U.S. Virgin Islands.

(ii) *Agency.* The provisions of this section apply throughout the Department of Defense (DoD), the Coast Guard, the Commissioned Corps of the USPHS, and the Commissioned Corps of the NOAA.

(3) *Authority and responsibility*—(i) *Legislative authority*—(A) *Joint regulations.* 10 U.S.C. chapter 55, 1076a authorizes the Secretary of Defense, in consultation with the Secretary of Health and Human Services and the Secretary of Transportation, to prescribe regulations for the administration of the Active Duty Dependents Dental Plan.

(B) *Administration.* 10 U.S.C. chapter 55 also authorizes the Secretary of Defense to administer the Active Duty Dependents Dental Plan for the Army, Navy, Air Force, and Marine Corps under DoD jurisdiction, the Secretary of Transportation to administer the Active Duty Dependents Dental Plan for the Coast Guard, when the Coast

Guard is not operating as a service in the Navy, and the Secretary of Health and Human Services to administer the Active Duty Dependents Dental Plan for the Commissioned Corps of the NOAA and the USPHS.

(C) *Care outside the United States.* 10 U.S.C. 1076a authorizes the Secretary of Defense to establish basic dental benefit plans for eligible dependents of members of the uniform services accompanying the member on permanent assignments of duty outside the United States.

(ii) *Organizational delegations and assignments*—(A) *Assistant Secretary of Defense (Health Affairs) (ASD(HA)).* The Secretary of Defense, by 32 CFR part 367, delegated authority to the ASD(HA) to provide policy guidance, management control, and coordination as required for all DoD health and medical resources and functional areas including health benefit programs. Implementing authority is contained in 32 CFR part 367. For additional implementing authority see §199.1 (c) of this part.

(B) *Evidence of eligibility.* The Department of Defense, through the defense Enrollment Eligibility Reporting System (DEERS), is responsible for establishing and maintaining a listing of persons eligible to receive benefits under the Active Duty Dependents Dental Plan.

(4) *Active duty dependents dental benefit plan.* This is a program of dental benefits provided by the U.S. Government under public law to specified categories of individuals who are qualified for these benefits by virtue of their relationship to one of the seven Uniformed Services, and their voluntary decision to accept enrollment in the program and cost share with the Government in the premium cost of the benefits. The Dependents Dental Plan is an insurance, service, or prepayment plan involving a contract guaranteeing the indemnification or payment of the enrolled member's dependents against a specified loss in return for a premium paid. Where state regulations, charter requirements, or other provisions of state and local regulation governing dental insurance and prepayment programs conflict with Federal law and regulation governing this Program, Federal law and regualtion shall govern. Otherwise, this Program shall comply with state and local regulatory requirements.

(5) *Plan funds*—(i) *Funding sources.* The funds used by the Active Duty Dependents Dental Plan are appropriated funds furnished by the Congress through the annual appropriation acts for the Department of Defense and the Department of Health and Human Services and funds collected by the Uniformed Services monthly through payroll deductions as premium shares from enrolled members.

(ii) *Disposition of funds.* Plan funds are paid by the Government as premiums to an insurer, service, or prepaid dental care organization under a contract negotiated by the Director, OCHAMPUS, or a designee, under the provisions of the Federal Acquisition Regulation (FAR).

(iii) *Plan.* The Director, OCHAMPUS or designee provides an insurance policy, service plan, or prepaid contract of benefits in accordance with those prescribed by law and regulation; as interpreted and adjudicated in accord with the policy, service plan, or contract and a dental benefits brochure; and as prescribed by requirements of the dental plan organization's contract with the government.

(iv) *Contracting out.* The method of delivery of the Active Duty Dependents Dental Benefit Plan is through a competitively procured contract. The Director, OCHAMPUS, or a designee is responsible for negotiating, under provisions of the FAR, a contract for dental benefits insurance or prepayment which includes responsibility for (A) development, publication, and enforcement of benefit policy, exclusions, and limitations in compliance with the law, regulation, and the contract provisions; (B) adjudicating and processing claims; and conducting related supporting activities, such as eligibility verification, provider relations, and beneficiary communications.

(6) *Role of Health Benefits Advisor (HBA).* The HBA is appointed (generally by the commander of a Uniformed Services medical treatment facility) to serve as an advisor to patients and staff in matters involving the Active Duty Dependents Dental

Plan. The HBA may assist beneficiaries or sponsors in applying for benefits, in the preparation of claims, and in their relations with OCHAMPUS and the dental plan insurer. However, the HBA is not responsible for the plan's policies and procedures and has no authority to make benefit determinations or obligate the plan's funds. Advice given to beneficiaries as to determination of benefits or level of payment is not binding on OCHAMPUS or the insurer.

(7) *Disclosure of information to the public.* Records and information acquired in the administration of the Active Duty Dependents Dental Plan are not records of the Department of Defense. The records are established by the Dependents Dental Plan insurer in accordance with standard business practices of the industry, and are used in the determination of eligibility, program management and operations, utilization review, quality assurance, program integrity, and underwriting in accordance with standard business practices. By contract, the records and information are subject to government audit and the government receives reports derived from them. Records and information specified by contract are provided by an outgoing insurer to a successor insurer in the event of a change in the contractor.

(8) *Equality of benefits.* All claims submitted for benefits under the Active Duty Dependents Dental Plan shall be adjudicated in a consistent, fair, and equitable manner, without regard to the rank of the sponsor.

(9) *Coordination of benefits.* The dental plan insurer shall conduct coordination of benefits for the Active Duty Dependents Dental Plan in accordance with generally accepted business practices.

(10) *Information on participating providers.* The Director, OCHAMPUS or designee, shall develop and make available to Uniformed Services Health Benefits Advisors and military installation personnel centers copies of lists of participating providers and providers accepting assignment for all localities with significant numbers of dependents of active duty members. In addition, the Director, OCHAMPUS or designee, shall respond to inquiries regarding availability of participating providers in areas not covered by the lists of participating providers.

(b) *Definitions.* For most definitions applicable to the provisions of this section, refer to section §199.2. The following definitions apply only to this section.

Assignment. Acceptance by a nonparticipating provider of payment directly from the insurer while reserving the right to charge the beneficiary or sponsor for any remaining amount of the fees for services which exceeds the prevailing fee allowance of the insurer.

Authorized provider. A dentist or dental hygienist specifically authorized to provide benefits under the Active Duty Dependents Dental Plan in paragraph (f) of this section.

Beneficiary. A dependent of an active duty member who has been enrolled in the Active Duty Dependents Dental Plan, and has been determined to be eligible for benefits, as set forth in paragraph (c) of this section.

Beneficiary liability. The legal obligation of a beneficiary, his or her estate, or responsible family member to pay for the costs of dental care or treatment received. Specifically, for the purposes of services and supplies covered by the Active Duty Dependents Dental Benefit Plan, beneficiary liability includes cost-sharing amounts and any amount above the prevailing fee determination by the insurer where the provider selected by the beneficiary is not a participating provider or a provider within an approved alternative delivery system. Beneficiary liability also includes any expenses for services and supplies not covered by the Active Duty Dependents Dental Benefit Plan, less any discount provided as a part of the insurer's agreement with an approved alternative delivery system.

By report. Dental procedures which are authorized as benefits only in unusual circumstances requiring justification of exceptional conditions related to otherwise authorized procedures. For example, a house call might be justified based on an enrolled dependent's severe handicap which prevents visits in the dentist's office for traditional prophylaxis. Alternatively, additional drugs might be required separately from an otherwise authorized

procedure because of an emergent reaction caused by drug interaction during the performance of a restoration procedure. These services are further defined in paragraph (e) of this section.

Cost-Share. The amount of money for which the beneficiary (or sponsor) is responsible in connection with otherwise covered dental services (other than disallowed amounts) as set forth in paragraphs (d) (6) and (e) of this section. Cost-sharing may also be referred to as ''co-payment.''

Defense Enrollment Eligibility Reporting System (DEERS). The automated system that is composed of two phases:

(1) Enrolling all active duty and retired service members, their dependents, and the dependents of deceased service members, and

(2) Verifying their eligibility for health care benefits in the direct care facilities and through the Active Duty Dependents Dental Plan.

Dental hygienist. Practitioner in rendering complete oral prophylaxis services, applying medication, performing dental radiography, and providing dental education services with a certificate, associate degree, or bachelor's degree in the field, and licensed by an appropriate authority.

Dentist. Doctor of Dental Medicine (D.M.D.) or Doctor of Dental Surgery (D.D.S.) who is licensed to practice dentistry by an appropriate authority.

Diagnostic services. Category of dental services including: (1) Clinical oral examinations, (2) radiographic examinations, and (3) diagnostic laboratory tests and examinations provided in connection with other dental procedures authorized as benefits of the Active Duty Dependents Dental Plan and further defined in paragraph (e) of this section.

Emergency palliative services. Minor procedures performed for the immediate relief of pain and discomfort as further defined in paragraph (e) of this section. This definition excludes those procedures other than minor palliative services which may result in the relief of pain and discomfort, but constitute the usual initial stage or conclusive treatment in procedures not otherwise defined as benefits of the Active Duty Dependents Dental Plan.

Endodontics. The etiology, prevention, diagnosis, and treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue as further defined in paragraph (e) of this section.

Initial determination. A formal written decision on an Active Duty Dependents Dental Plan claim, a request by a provider for approval as an authorized provider, or a decision disqualifying or excluding a provider as an authorized provider under the Active Duty Dependents Dental Plan. Rejection of a claim or a request for benefit or provider authorization for failure to comply with administrative requirements, including failure to submit reasonably requested information, is not an initial determination. Responses to general or specific inquiries regarding Active Duty Dependent Dental Plan benefits are not initial determinations.

Laboratory and Pathology Services. Laboratory and pathology examinations (including machine diagnostic tests that produce hard-copy results) ordered by a dentist when necessary to, and rendered in connection with other covered dental services.

Nonparticipating provider. A dentist or dental hygienist that furnished dental services to an Active Duty Dependents Dental Plan beneficiary, but who has not agreed to participate or to accept the insurer's fee allowances and applicable cost share as the total charge for the services. A nonparticipating provider looks to the beneficiary or sponsor for final responsibility for payment of his or her charge, but may accept payment (assignment of benefits) directly from the insurer or assist the beneficiary in filing the claim for reimbursement by the contractor. Where the nonparticipating provider does not accept payment directly from the insurer, the insurer pays the beneficiary or sponsor, not the provider.

Oral surgery. Surgical procedures performed in the oral cavity as further defined in paragraph (e) of this section.

Orthodontics. The supervision, guidance, and correction of the growing or mature dentofacial structures, including those conditions that require movement of teeth or correction or malrelationships and malformations of

their related structures and adjustment of relationships between and among teeth and facial bones by the application of forces and/or the stimulation and redirection of functional forces within the craniofacial complex.

Participating provider. A dentist or dental hygienist who has agreed to accept the insurer's reasonable fee allowances or other fee arrangements as the total charge (even though less than the actual billed amount), including provision for payment to the provider by the beneficiary (or sponsor) of any cost-share for services.

Party to a hearing. An appealing party or parties, the insurer, and OCHAMPUS.

Party to the initial determination. Includes the Active Duty Dependents Dental Plan, a beneficiary of the Active Duty Dependents Dental Plan and a participating provider of services whose interests have been adjudicated by the initial determination. In addition, a provider who has been denied approval as an authorized Active Duty Dependents Dental Plan provider is a party to that initial determination, as is a provider who is disqualified or excluded as an authorized provider, unless the provider is excluded under another federal or federally funded program. See paragraph (h) of this section for additional information concerning parties not entitled to administrative review under the Active Duty Dependents Dental Plan appeals procedures.

Periodontics. The examination, diagnosis, and treatment of diseases affecting the supporting structures of the teeth as further defined in paragraph (e) of this section.

Preventive services. Traditional prophylaxis including scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth as further defined in paragraph (e) of this section.

Prosthodontics. The diagnosis, planning, making, insertion, adjustment, relinement, and repair of artificial devices intended for the replacement of missing teeth and associated tissues as further defined in paragraph (e) of this section.

Provider. A dentist or dental hygienist as specified in paragraph (f) of this section.

Representative. Any person who has been appointed by a party to the initial determination as counsel or advisor and who is otherwise eligible to serve as the counsel or advisor of the party to the initial determination, particularly in connection with a hearing.

Restorative services. Restoration of teeth including those procedures commonly described as amalgam restorations, resin restorations, pin retention, and stainless steel crowns for primary teeth as further defined in paragraph (e) of this section.

Sealants. A material designed for application on the occlusal surfaces of specified teeth to seal the surface irregularities to prevent ingress of oral fluids, food, and debris in order to prevent tooth decay.

(c) *Enrollment and eligibility*—(1) *General.* 10 U.S.C. 1076a, 1072(2)(A), (D) or (I) and 1072(6) set forth those persons who are eligible for voluntary enrollment in the Active Duty Dependents Dental Benefit Plan. A determination that a person is eligible for voluntary enrollment does not automatically entitle that person to benefit payments. The person must be enrolled in accordance with the provisions set forth in this section and meet any additional eligibility requirements in other sections of this part in order for dental benefits to be extended.

(2) *Persons eligible. Dependent.* A person who bears one of the following relationships to an active duty member (under a call or order that does not specify a period of 30 days or less).

(i) *Spouse.* A lawful husband or wife, regardless of whether or not dependent upon the active duty member.

(ii) *Child.* To be eligible, the child must be unmarried and meet one of the requirements of this section.

(A) A legitimate child.

(B) An adopted child whose adoption has been completed legally.

(C) A legitimate stepchild.

(D) An illegitimate child of a male member whose paternity has been determined judicially, or an illegitimate child of record of a female member who has been directed judicially to support the child.

(E) An illegitimate child of a male active duty member whose paternity has not been determined judicially, or

an illegitimate child of record of a female active duty member who:

(*1*) Resides with or in a home provided by the member and

(*2*) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(F) An illegitimate child of the spouse of an active duty member (that is, the active duty member's stepchild) who:

(*1*) Resides with or in a home provided by the active duty member or the parent who is the spouse of the member and

(*2*) Is and continues to be dependent upon the member for over 50 percent of his or her support.

(G) A child placed in the custody of a service member by a court or recognized adoption agency on or after October 5, 1994, in anticipation of a legal adoption.

(H) In addition to meeting one of the criteria (A) through (F) of this paragraph (c)(2), the child:

(*1*) Must not be married.

(*2*) Must be in one of the following three age groups:

(*A*) Not passed his or her 21st birthday.

(*B*) Passed his or her 21st birthday, but incapable of self-support because of a mental or physical incapacity that existed before his or her 21st birthday and dependent on the member for over 50 percent of his or her support. Such incapacity must be continuous. If the incapacity significantly improves or ceases at any time after age 21, even if such incapacity recurs subsequently, eligibility cannot be reinstated on the basis of the incapacity. If the child was not handicapped mentally or physically at his or her 21st birthday, but becomes so incapacitated after that time, no eligibility exists on the basis of the incapacity.

(*C*) Passed his or her 21st birthday, but not his or her 23rd birthday, dependent upon the member for over 50 percent of his or her support, and pursuing a full-time course of education in an institution of higher learning approved by the Secretary of Defense or the Department of Education (as appropriate) or by a state agency under 38 U.S.C., chapters 34 and 35.

NOTE: Courses of education offered by institutions listed in the ''Education Directory, Part 3, Higher Education'' or ''Accredited Higher Institutions,'' issued periodically by the Department of Education meet the criteria approved by the Secretary of Defense or the Department of Education, (refer to §199.3(b)(2)(iv)(C)(*1*) of this section). For determination of approval of courses offered by a foreign institution, by an institution not listed in either of the above directories, or by an institution not approved by a state agency pursuant to chapters 34 and 35 of 38 U.S.C., a statement may be obtained from the Department of Education, Washington, DC 20202.

(3) *Enrollment*—(i) *Basic active duty dependents dental benefit plan.* The dependent dental plan is effective from August 1, 1987, up to the date of implementation of the Expanded Active Duty Dependents Dental Benefit Plan.

(A) *Initial enrollment.* Eligible dependents of members on active duty status as of August 1, 1987 are automatically enrolled in the Active Duty Dependents Dental Plan, except where any of the following conditions apply:

(*1*) Remaining period of active duty at the time of contemplated enrollment is expected by the active duty member or the Uniformed Service to be less than two years, except that such members' dependents may be enrolled during the initial enrollment period for benefits beginning August 1, 1987 provided that the member had at least six months remaining in the initial enlistment term. Enrollment of dependents is for a period of 24 months, subject to the exceptions provided in paragraph (c)(5) of this section.

(*2*) Active duty member had completed an election to disenroll his or her dependents from the Basic Active Duty Dependents Dental Benefit Plan.

(*3*) Active duty member had only one dependent who is under four years of age as of August 1, 1987, and the member did not complete an election form to enroll the child.

(B) *Subsequent enrollment.* Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(C) *Inclusive family enrollment.* All eligible dependents of the active duty member must be enrolled if any were

enrolled, except that a member may elect to enroll only those dependents who are remotely located from the member (e.g., a child living with a divorced spouse or a child in college).

(ii) *Expanded active duty dependents dental benefit plan.* The expanded dependents dental plan is effective on August 1, 1993. The Basic Active Duty Dependents Dental Benefit Plan terminated upon implementation of the expanded plan.

(A) *Initial enrollment.* Enrollment in the Expanded Active Duty Dependents Dental Benefit Plan is automatic for all eligible dependents of active duty members known to have at least 24 months remaining in service, and for those dependents enrolled in the Basic Dependents Dental Benefit Plan regardless of the military member's remaining time in service unless the active duty member elects to disenroll his or her dependents during the one-time disenrollment option period (one-month period before the date on which the expanded plan went into effect, and for 4 months after the beginning date). Those active duty members who intend to remain in the service for 24 months or more, whose dependents were not automatically enrolled, may enroll them at their military personnel office by completing the appropriate Uniformed Services Active Duty Dependents Dental Plan Enrollment Election Form. Use of the new plan during the one-time disenrollment option period by a dependent enrolled in the Basic Active Duty Dependents Dental Benefit Plan, constitutes acceptance of the plan by the military sponsor and his or her family. Once the new plan is used, the family cannot be disenrolled, and the premiums will not be refunded.

(B) *Subsequent enrollment.* Eligible active duty members may elect to enroll their dependents for a period of not less than 24 months, provided there is an intent to remain on active duty for a period of not less than two years by the member and the Uniformed Service.

(C) *Inclusive family enrollment.* All eligible dependents of the active duty member must be enrolled if any are enrolled, except as defined in paragraphs (c)(3)(ii)(C) (*1*) and (*2*) of this section.

(*1*) Enrollment will be by either single or family premium as defined herein:

(*i*) *Single premium.* (*A*) Sponsors with only one family member age four (4) or older who elect to enroll that family member; or

(*B*) Sponsors who have more than one family member under age four (4) may elect to enroll one (1) family member under age four (4); or

(*C*) Sponsors who elect to enroll one (1) family member age four or older but may have any number of family members under age four (4) who are not elected to be covered. At such time when the sponsor elects to enroll more than one (1) eligible family member, regardless of age, the sponsor must then enroll under a family premium which covers all eligible family members.

(*ii*) *Family premium.* (*A*) Sponsors with two (2) or more eligible family members age four (4) or older must enroll under the family premium.

(*B*) Sponsors with one (1) eligible family member age four (4) or older and one (1) or more eligible family members under the age of four may elect to enroll under a family premium.

(*C*) Under the family premium, all eligible family members of the sponsor are enrolled.

(*2*) *Exceptions.* (*i*) A sponsor may elect to enroll only those eligible family members residing in one location when the sponsor has other eligible family members residing in two or more physically separate locations (e.g., children living with a divorced spouse; children attending college).

(*ii*) Instances where a family member requires hospital or special treatment environment (due to a medical, physical handicap, or mental condition) for dental care otherwise covered by the dental plan, the family member may be excluded from the dental plan enrollment and may continue to receive care from a military treatment facility.

(D) *Enrollment period.* Enrollment of dependents is for a period of 24 months except when:

(*1*) The dependent's enrollment is based on his or her enrollment in the Basic Active Duty Dependents Dental Benefit; or

(*2*) One of the conditions for disenrollment in paragraph (c)(5) of this section is met.

(4) *Beginning dates of eligibility*—(i) *Basic active duty dependents dental benefit plan*—(A) *Initial enrollment.* The beginning date of eligibility for benefits is August 1, 1987.

(B) *Subsequent enrollment.* The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than September 1, 1987.

(ii) *Expanded active duty dependents dental benefit plan*—(A) *Initial enrollment.* The beginning date of eligibility for benefits is April 1, 1993.

(B) *Subsequent enrollment.* The beginning date of eligibility for benefits is the first day of the month following the month in which the election of enrollment is completed, signed, and received by the active duty member's Service representative, except that the date of eligibility shall not be earlier than the first of the month following the month of implementation of the expanded benefit.

(5) *Changes in and termination of enrollment*—(i) *Changes in status of active duty member.* When an active duty member's period of active duty ends for any reason, his or her dependents lose their eligibility as of 11:59 p.m. of the last day of the month in which the active duty ends.

(ii) *Termination of eligibility for basic pay.* When a member ceases to be eligible for basic pay, eligibility of the member's dependents for benefits under the Dependents Dental Plan terminates as of 11:59 p.m. of the day the member became ineligible for basic pay and the Uniformed Service must notify the Plan of disenrollment based on termination of eligibility for basic pay. The member whose eligibility for basic pay is subsequently restored may enroll his or her dependents for a minimum of two years in accordance with § 199.13(c)(3)(ii).

(iii) *Changes in status of dependent*—(A) *Divorce.* A spouse separated from an active duty member by a final divorce decree loses all eligibility based on his or her former marital relationship as of 11:59 p.m. of the last day of the month in which the divorce becomes final. The eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the divorce. An unadopted stepchild, however, loses eligibility with the termination of the marriage, also as of 11:59 p.m. of the last day of the month in which the divorce becomes final.

(B) *Annulment.* A spouse whose marriage to an active duty member is dissolved by annulment loses eligibility as of 11:59 p.m. of the last day of the month in which the court grants the annulment order. The fact that the annulment legally declares the entire marriage void from its inception does not affect the termination date of eligibility. When there are children, the eligibility of the member's own children (including adopted and eligible illegitimate children) is unaffected by the annulment. An unadopted stepchild, however, loses eligibility with the annulment of the marriage, also as of 11:59 p.m. of the last day of the month in which the court grants the annulment order.

(C) *Adoption.* A child of an active duty member who is adopted by a person, other than a person whose dependents are eligible for the Active Duty Dependents Dental Plan benefits while the active duty member is living, thereby severing the legal relationship between the child and the sponsor, loses eligibility as of 11:59 p.m. of the last day of the month in which the adoption becomes final.

(D) *Marriage of child.* A child of an active duty member who marries a person whose dependents are not eligible for the Active Duty Dependents Dental Plan, loses eligibility as of 11:59 p.m. on the last day of the month in which the marriage takes place. However, should the marriage be terminated by death, divorce, or annulment before the child is 21 years old, the child again becomes eligible for enrollment as a dependent as of 12:00 a.m. of the first day of the month following the month in which the occurrence takes place that terminates the marriage and continues up to age 21 if the child does not remarry before that time. If the marriage

terminates after the child's 21st birthday, there is no reinstatement of eligibility.

(E) *Disabling illness or injury of child age 21 or 22 who has eligibility based on his or her student status.* A child 21 or 22 years old who is pursuing a full-time course of higher education and who, either during the school year or between semesters, suffers a disabling illness or injury with resultant inability to resume attendance at the institution remains eligible for dental benefits for 6 months after the disability is removed or until the student passes his or her 23rd birthday, whichever occurs first. However, if recovery occurs before the 23rd birthday and there is resumption of a full-time course of higher education, dental benefits can be continued until the 23rd birthday. The normal vacation periods during an established school year do not change the eligibility status of a dependent child 21 or 22 years old in full-time student status. Unless an incapacitating condition existed before, and at the time of, a dependent child's 21st birthday, a dependent child 21 or 22 years old in student status does not have eligibility related to mental or physical incapacity as described in §199.3(b)(2)(iv)(C)(*2*) of this section.

(iv) *Disenrollment because of no eligible dependents.* When an active duty member ceases to have any eligible dependents, the member must disenroll.

(v) *Option to disenroll as a result of a change in active duty station.* When an active duty member transfers with enrolled family members to a duty station where space-available dental care is readily available at the local military clinic, the member may elect within 90 days of the transfer to disenroll from the plan. If the member is later transferred to a duty station where dental care is not available in the local military clinic, the member may re-enroll his or her dependents in the plan.

(vi) *Option to disenroll after an initial two-year enrollment.* When an active duty member's enrollment of his or her dependents has been in effect for a continuous period of two years, the member may disenroll his or her dependents at any time. Subsequently, the member may enroll his or her dependents for another minimum period of two years.

(6) *Eligibility determination and enrollment*—(i) *Eligibility determination and enrollment responsibility of Uniformed Services.* Determination of a person's eligibility and processing of enrollment in the Active Duty Dependents Dental Benefit Plan is the responsibility of the active duty member's Uniformed Service. For the purpose of program integrity, the appropriate Uniformed Service shall, upon request of the Director, OCHAMPUS, review the eligibility of a specific person when there is reason to question the eligibility status. In such cases, a report on the result of the review and any action taken will be submitted to the Director, OCHAMPUS, or a designee.

(ii) *Procedures for determination of eligibility.* Uniformed Services identification cards do not distinguish eligibility for the Active Duty Dependents Dental Plan. Procedures for the determination of eligibility are identified in §199.3(f)(2) of this part, except that Uniformed Services identification cards do not provide evidence of eligibility for the dental plan.

(7) *Evidence of eligibility required.* Eligibility and enrollment in the Active Duty Dependents Dental Plan will be verified through the DEERS (DoD 1341.1–M, ''Defense Enrollment Eligibility Reporting System (DEERS) Program Manual,'' May 1982).

(i) *Acceptable evidence of eligibility and enrollment.* Eligibility information established and maintained in the DEERS files is the only acceptable evidence of eligibility.

(ii) *Responsibility for obtaining evidence of eligibility.* It is the responsibility of the active duty member, or Active Duty Dependent Dental Plan beneficiary, parent, or legal representative, when appropriate, to enroll with a Uniformed Service authorized representative and provide adequate evidence for entry into the DEERS file to establish eligibility for the Active Duty Dependents Dental Plan, and to ensure that all changes in status that may affect enrollment and eligibility are reported immediately to the appropriate Uniformed Service for action. Ineligibility for benefits is presumed in the absence of prescribed enrollment

and eligibility evidence in the DEERS file.

(8) *Continuation of eligibility for dependents of service members who die on active duty*. Eligible dependents of service members who die on or after October 1, 1993, while on active duty for a period of more than 30 days and who are enrolled in the dental benefits plan on the date of the death of the member shall be eligible for continued enrollment in the dental benefits plan for up to one year from the date of the service member's death.

(d) *Premium sharing*—(1) *General.* Active duty members enrolling their dependents in the Active Duty Dependents Dental Plan shall be required to pay a share of the premium cost for their dependents.

(2) *Premium classifications.* Premium classifications are established by the Secretary of Defense, or designee, and provide for a minimum of two classifications, single and family.

(3) *Premium amounts.* The premium amounts to be paid for the Active Duty Dependents Dental plan are established by the Secretary of Defense or designee.

(4) *Proportion of member's premium share.* The proportion of premium share to be paid by the member is established by the Secretary of Defense or designee, at not more than 40 percent of the total premium.

(5) *Pay deduction.* The member's premium share shall be deducted from the basic pay of the member.

(e) *Plan benefits*—(1) *General*—(i) *Scope of benefits.* The Active Duty Dependents Dental Benefit Plan provides coverage for diagnostic and preventive services, sealants, restorative services, endodontics, periodontics, prosthodontics, orthodontics and oral surgery to eligible, enrolled dependents of active duty members as set forth in paragraph (c) of this section.

(ii) *Authority to act for the plan.* The authority to make benefit determinations and authorize plan payments under the Active Duty Dependents Dental Plan rests primarily with the insurance, service plan, or prepayment dental plan contractor, subject to compliance with federal law and regulation and government contract provisions. The Director, OCHAMPUS, or designee, provides required benefit policy decisions resulting from changes in federal law and regulation and appeal decisions. No other persons or agents (such as dentists or Uniformed Services health benefits advisors) have such authority.

(iii) *Right to information.* As a condition precedent to the provision of benefits hereunder, the Director, OCHAMPUS, or designee, shall be entitled to receive information from an authorized provider or other person, institution, or organization (including a local, state, or U.S. Government agency) providing services or supplies to the beneficiary for which claims for benefits are submitted. While establishing enrollment and eligibility, benefits, and benefit utilization and performance reporting information standards; the government has not established and does not maintain a system of records and information for the Dependents Dental Plan. By contract, the government audits the adequacy and accuracy of the dental contractor's system of records and requires access to information and records to meet program accountabilities. Such information and records may relate to attendance, testing, monitoring, examination, or diagnosis of dental disease or conditions; or treatment rendered; or services and supplies furnished to a beneficiary; and shall be necessary for the accurate and efficient administration and payment of benefits under this plan. Before a determination will be made on a claim of benefits, a beneficiary or active duty member must provide particular additional information relevant to the requested determination, when necessary. Failure to provide the requested information may result in denial of the claim. The recipient of such information shall in every case hold such records confidential except when:

(A) Disclosure of such information is necessary to the determination by a provider or the Plan contractor of beneficiary enrollment or eligibility for coverage of specific services;

(B) Disclosure of such information is authorized specifically by the beneficiary;

(C) Disclosure is necessary to permit authorized governmental officials to

investigate and prosecute criminal actions; or

(D) Disclosure constitutes a standard and acceptable business practice commonly used among dental insurers which is consistent with the principle of preserving confidentiality of personal information and detailed clinical data. For example, the release of utilization information for the purpose of determining eligibility for certain services, such as the number of dental prophylaxis procedures performed for a beneficiary, is authorized.

(E) Disclosure by the Director, OCHAMPUS, or designee, is for the purpose of determining the applicability of, and implementing the provisions of, other dental benefits coverage or entitlement.

(iv) *Dental insurance policy, prepayment, or dental service plan contract.* The Director, OCHAMPUS, or designee, shall develop a standard insurance policy, prepayment agreement, or dental service plan contract designating OCHAMPUS as the policyholder or purchaser. The policy shall be in the form customarily employed by the dental plan insurer, subject to its compliance with federal law and the provisions of this Regulation.

(v) *Dental benefits brochure*—(A) *Content.* The Director, OCHAMPUS, or designee, shall establish a dental benefits brochure explaining the benefits of the plan in common lay terminology. The brochure shall include the limitations and exclusions and other benefit determination rules for administering the benefits in accordance with the law and this part. The brochure shall include the rules for adjudication and payment of claims, appealable issues, and appeal procedures in sufficient detail to serve as a common basis for interpretation and understanding of the rules by providers, beneficiaries, claims examiners, correspondence specialists, employees and representatives of other government bodies, health benefits advisors, and other interested parties. Any conflict which may occur between the dental benefits brochure and law or regulation shall be resolved in favor of law and regulation.

(B) *Distribution.* The dental benefits brochure shall be printed and distributed with the assistance of the Uniformed Services health benefits advisors, major personnel centers at Uniformed Services installations, and authorized providers of care to all active duty members enrolling their dependents.

(vi) *Utilization review and quality assurance.* Claims submitted for benefits under the Active Duty Dependents Dental Plan are subject to review by the Director, OCHAMPUS or designee for quality of care and appropriate utilization. The Director, OCHAMPUS or designee is responsible for appropriate utilization review and quality assurance standards, norms, and criteria consistent with the level of benefits.

(vii) *Alternative course of treatment policy.* The Director, OCHAMPUS or designee may establish, in accordance with generally accepted dental benefit practices, an alternative course of treatment policy which provides reimbursement in instances where the dentist and beneficiary select a more expensive service, procedure, or course of treatment than is customarily provided. The benefit policy must meet the following conditions:

(A) The service, procedure, or course of treatment must be consistent with sound professional standards of dental practice for the dental condition concerned.

(B) The service, procedure, or course of treatment must be a generally accepted alternative for a service or procedure covered by this plan for the dental condition.

(C) Payment for the alternative service or procedure may not exceed the lower of the prevailing limits for the alternative procedure, the prevailing limits or scheduled allowance for the otherwise authorized benefit procedure for which the alternative is substituted, or the actual charge for the alternative procedure.

(2) *Benefits*—(i) *Diagnostic and preventive services.* Benefits may be extended for those dental services described as oral examination, diagnostic, and preventive services defined as traditional prophylaxis (i.e., scaling deposits from teeth, polishing teeth, and topical application of fluoride to teeth) when performed directly by dentists or dental hygienists as authorized under paragraph (f) of this section. These

services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules approved by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) *Diagnostic services.* (*1*) Clinical oral examinations.

(*2*) Radiographs.

(*3*) Tests and laboratory examinations.

(B) *Preventive services.* (*1*) Dental prophylaxis.

(*2*) Topical fluoride treatment (office procedure).

(*3*) Sealants.

(*4*) Space maintenance (passive appliances).

(ii) *Adjunctive general services (services ''by report'').* The following categories of services are authorized when performed directly by dentists or dental hygienists only in unusual circumstances requiring justification of exceptional conditions directly related to otherwise authorized procedures. Use of the procedures may not result in the fragmentation of services normally included in a single procedure. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of service:

(A) Emergency oral examinations.

(B) Palliative emergency treatment of dental pain.

(C) Professional consultation.

(D) Professional visits.

(E) Drugs.

(F) Post-surgical complications.

(iii) *Restorative.* Benefits may be extended for basic restorative services when performed directly by dentists or dental hygienists, or under orders and supervision by dentists, as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) *Restorative services.* (*1*) Amalgam restorations.

(*2*) Silicate restorations.

(*3*) Resin restorations.

(*4*) Prefabricated crowns.

(*5*) Pin retention.

(B) *Other restorative services.* (*1*) Diagnostic casts.

(*2*) Onlay restoration—metallic.

(*3*) Crowns.

(iv) *Endodontic services.* Benefits may be extended for those dental services involved in treatment of diseases and injuries affecting the dental pulp, tooth root, and periapical tissue when performed directly by dentists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) Pulp capping—indirect.

(B) Pulpotomy.

(C) Root canal therapy.

(D) Periapical services.

(E) Hemisection.

(v) *Periodontic services.* Benefits may be extended for those dental services involved in prevention and treatment of diseases affecting the supporting structures of the teeth to include periodontal prophylaxis, gingivectomy or gingivoplasty, gingival curettage, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) Surgical services.

(B) Periodontal scaling and root planing.

(C) Unscheduled dressing change.

(vi) *Prosthodontic services.* Benefits may be extended for those dental services involved in fabrication, insertion, adjustment, relinement, and repair of artificial teeth and associated tissues to include removable complete and partial dentures, fixed crowns and bridges when performed directly by dentists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) *Prosthodontics (removable).* (*1*) Complete/partial dentures.

(*2*) Adjustments to removable prosthesis.

(*3*) Repairs to complete/partial dentures.

(*4*) Denture rebase procedures.

(*5*) Denture reline procedures.

(*6*) Interim complete/partial dentures.

(*7*) Tissue conditioning.

(B) *Prosthodontics (fixed).* (*1*) Bridge pontics.

(*2*) Retainers (by report).

(*3*) Bridge retainers-crowns.

(*4*) Other fixed prosthetic services.

(vii) Orthodontic services. Benefits may be extended for the supervision, guidance, and correction of growing or mature dentofacial structures, including those conditions that require movement of teeth or correction of malrelationships and malformations through the use of orthodontic procedures and devices when performed directly by dentists as authorized under paragraph (f) of this section to include in-process orthodontics. Coverage of in-process orthodontics is limited to services rendered on or after the date of enrollment in the expanded dependents dental play. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) Minor treatment for tooth guidance.

(B) Minor treatment to control harmful habits.

(C) Interceptive orthodontic treatment.

(D) Comprehensive orthodontic treatment—transitional dentition.

(E) Comprehensive orthodontic treatment—permanent dentition.

(F) Treatment of the atypical or extended skeletal case.

(G) Post-treatment stabilization.

(viii) *Oral surgery services.* Benefits may be extended for basic surgical procedure of the extraction, reimplantation, stabilization and repositioning of teeth, alveoloplasties, incision and drainage of abscesses, suturing of wounds, biopsies, etc., when performed directly by dentists as authorized under paragraph (f) of this section. These services are defined (subject to the dental plan's exclusions, limitations, and benefit determination rules as adopted by OCHAMPUS) using the American Dental Association's Code on Dental Procedures and Nomenclature as listed in the Current Dental Terminology manual to include the following categories of services:

(A) Extractions.

(B) Surgical extractions.

(C) Other surgical procedures.

(D) Alveoloplasty—surgical preparation of ridge for denture.

(E) Surgical incision and drainage of abscess—intraoral soft tissue.

(F) Repair of traumatic wounds.

(G) Complicated suturing.

(H) Excision of pericoronal gingiva.

(ix) *Exclusion of adjunctive dental care.* Under limited circumstances, benefits are available for dental services and supplies under CHAMPUS when the dental care is medically necessary in the treatment of an otherwise covered medical (not dental) condition, is an integral part of the treatment of such medical condition, and is essential to the control of the primary medical condition; or is required in preparation for, or as the result of, dental trauma which may be or is caused by medically necessary treatment of an injury or disease (iatrogenic). These benefits are excluded under the Active Duty Dependents Dental Plan. For further information on adjunctive dental care

benefits under CHAMPUS, see § 199.4(e)(10).

(x) *Exclusion of benefit services performed in military dental care facilities.* Except for emergency treatment, dental care provided outside the United States, and services incidental to noncovered services, dependents enrolled in the Active Duty Dependents Dental Plan may not obtain those services which are benefits of the Plan in military dental care facilities. Enrolled dependents may continue to obtain noncovered services from military dental care facilities subject to the provisions for space available care.

(xi) *Benefit limitations and exclusions.* The Director, OCHAMPUS or designee may establish such exclusions and limitations as are consistent with those established by dental insurance and prepayment plans to control utilization and quality of care for the services and items covered by this dental plan.

(3) *Beneficiary and sponsor liability*—(i) *Diagnostic and preventive services.* Enrolled dependents of active duty members or their sponsors are responsible for the payment of only those amounts which are for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer, except in the case of sealants where the dependents or their sponsors will also be responsible for payment of 20 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, the dental plan will reimburse the dependent, or sponsor, or the nonparticipating provider selected by the dependent within 35 miles of the dependent's place of residence at the level of the provider's usual fees less 20 percent of the insurer's allowable amount for sealants.

(ii) *Restorative services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 20 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care, except in the case of crowns and casts where the dependents or their sponsors will be responsible for payment of 50 percent of the insurer's determined allowable amount. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 20 percent (50 percent in the case of crowns and casts) of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(iii) *Endodontic, periodontic, and oral surgery services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 40 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 40 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 40 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(iv) *Prosthodontic and orthodontic services.* Enrolled dependents of active duty members or their sponsors are responsible for payment of 50 percent of the amounts determined by the insurer for services rendered by participating providers of care, or 50 percent of these amounts plus any remainder of the charges made by nonparticipating providers of care. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of 50 percent of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence.

(v) *Adjunctive general services (services ''by report'').* The beneficiary or sponsor

liability is dependent on the particular service provided. Emergency oral examinations and palliative emergency treatment of dental pain are paid in full except for those amounts for services rendered by nonparticipating providers of care which exceed the equivalent of the statewide or regional prevailing fee levels as established by the insurer which are the responsibility of the enrolled dependents or their sponsors. Enrolled dependents or their sponsors are responsible for payment of 20 percent of the amounts determined by the insurer for professional consultations/visits and postsurgical services and 50 percent for covered medications when provided by participating providers of care, or these percentage payments plus any remaining amounts in excess of the prevailing charge limits established by the insurer for services rendered by nonparticipating providers, subject to the exceptions for dependent lack of access to participating providers as provided in paragraphs (e)(3)(i) through (e)(3)(iv) of this section. The contracting dental insurer may recognize a ''by report'' condition by providing additional allowance to the primary covered procedure instead of recognizing or permitting a distinct billing for the ''by report'' service.

(vi) *Amounts over the dental insurer's established allowance for charges.* It is the responsibility of the dental plan insurer to determine allowable charges for the procedures identified as benefits of this plan. All benefits of the plan are based on the insurer's determination of the allowable charges, subject to the exceptions for lack of access to participating providers as provided in paragraphs (e)(3)(i) through (e)(3)(iv) of this section.

(vii) *Maximum coverage amounts.* Enrolled dependents of active duty members are subject to an annual maximum coverage amount for non-orthodontic dental benefits and a lifetime maximum coverage amount for orthodontics as established by the Secretary of Defense or designee.

(f) *Authorized providers*—(1) *General.* This section sets forth general policies and procedures that are the basis for the Active Duty Dependents Dental Plan cost sharing of dental services and supplies provided by or under the direct supervision or prescription by dentists, and by dental hygienists, within the scope of their licensure.

(i) *Listing of provider does not guarantee payment of benefits.* The fact that a type of provider is listed in this section is not to be construed to mean that the Active Duty Dependents Dental Plan will pay automatically a claim for services or supplies provided by such a provider. The Director, OCHAMPUS or designee also must determine if the patient is an eligible beneficiary, whether the services or supplies billed are authorized and medically necessary, and whether any of the authorized exclusions of otherwise qualified providers presented in this section apply.

(ii) *Conflict of interest.* See § 199.9(d).

(iii) *Fraudulent practices or procedures.* See § 199.9(c) of this part.

(iv) *Utilization review and quality assurance.* Services and supplies furnished by providers of care shall be subject to utilization review and quality assurance standards, norms, and criteria established by the dental plan. Utilization review and quality assurance assessments shall be performed by the dental plan consistent with the nature and level of benefits of the plan, and shall include analysis of the data and findings by the dental plan insurer from other dental accounts.

(v) *Provider required.* In order to be considered benefits, all services and supplies shall be rendered by, prescribed by, or furnished at the direction of, or on the order of an Active Duty Dependents Dental Plan authorized provider practicing within the scope of his or her license.

(vi) *Participating provider.* An authorized provider may elect to participate and accept the fee or charge determinations as established and made known to the provider by the dental plan insurer. The fee or charge determinations are binding upon the provider in accordance with the dental plan insurer's procedures for participation. The authorized provider may not participate on a claim-by-claim basis. The participating provider must agree to accept, within one day of a request for appointment, beneficiaries in need of emergency palliative treatment. Payment to the participating provider

is based on the lower of the actual charge or the insurer's determination of the allowable charge. Payment is made directly to the participating provider, and the participating provider may only charge the beneficiary the percent cost-share of the insurer's allowable charge for those benefit categories as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section, in addition to the charges for any services not authorized as benefits.

(vii) *Nonparticipating provider.* An authorized provider may elect for all beneficiaries not to participate and request the beneficiary or sponsor to pay any amount of the provider's billed charge in excess of the dental plan insurer's determination of allowable charges. Neither the government nor the dental plan insurer shall have any responsibility for any amounts over the allowable charges as determined by the dental plan insurer, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the percent cost-share as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

(A) *Assignment.* A nonparticipating provider may accept assignment of claims for beneficiaries certifying their willingness to make such assignment by filing the claims completed with the assistance of the beneficiary or sponsor for direct payment by the dental plan insurer to the provider.

(B) *Nonassignment.* A nonparticipating provider for all beneficiaries may request the beneficiary or sponsor to file the claim directly with the dental plan insurer, making arrangements with the beneficiary or sponsor for direct payment by the beneficiary or sponsor.

(2) *Dentists.* Subject to standards of participation provisions of this part, the following are authorized providers of care:

(i) Doctors of Dental Surgery (D.D.S.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

(ii) Doctors of Dental Medicine (D.M.D.) having a degree from an accredited school of dentistry, licensed to practice dentistry by a state board of dental examiners, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

(3) *Dental hygienists.* Subject to state licensure laws and standards of participation provisions of this part, dental hygienists having an associate degree, certificate, or baccalaureate degree from an accredited school of dental hygiene, licensed to practice dental hygiene by a state board, and practicing within the scope of their licenses, whether in individual, group, or clinic practice settings.

NOTE: Dental hygienists may independently bill and receive payment only in the few states where the state licensure laws authorized them as independent providers of care. In nearly all states at the present time, the dental hygienist performs services under the supervision of a dentist and the Dependents Dental Plan will pay for such services in these states only when supervised and billed by a dentist.

(4) *Alternative delivery system*—(i) *General.* Alternative delivery systems may be established by the Director, OCHAMPUS or designee as authorized providers. Only dentists and dental hygienists shall be authorized to provide or direct the provision of authorized services and supplies in an approved alternative delivery system.

(ii) *Defined.* An alternative delivery system may be any approved arrangement for a preferred provider organization, capitation plan, dental health maintenance or clinic organization, or other contracted arrangement which is approved by OCHAMPUS in accordance with requirements and guidelines.

(iii) *Elective or exclusive arrangement.* Alternative delivery systems may be established by contract or other arrangement on either an elective or exclusive basis for beneficiary selection of participating and authorized providers in accordance with contractual requirements and guidelines.

(iv) *Provider election of participation.* Otherwise authorized providers must be provided with the opportunity of applying for participation in an alternative delivery system and of achieving participation status based on reasonable criteria for timeliness of application, quality of care, cost containment, geographic location, patient availability, and acceptance of reimbursement allowance.

(v) *Limitation on authorized providers.* Where exclusive alternative delivery systems are established, only providers participating in the alternative delivery system are authorized providers of care. In such instances, the dental plan shall continue to pay beneficiary claims for services rendered by otherwise authorized providers in accordance with established rules for reimbursement of nonparticipating providers where the beneficiary has established a patient relationship with the nonparticipating provider prior to the dental plan's proposal to subcontract with the alternative delivery system.

(vi) *Charge agreements.* Where the alternative delivery system employs a discounted fee-for-service reimbursement methodology or schedule of charges or rates which includes all or most dental services and procedures recognized by the American Dental Association, Council on Dental Care Programs ''Code on Dental Procedures and Nomenclature (6th Revision),'' the discounts or schedule of charges or rates for all dental services and procedures shall be extended by its participating providers to beneficiaries of the Active Duty Dependents Dental Plan as an incentive for beneficiary participation in the alternative delivery system.

(5) *Billing practices.* The Director, OCHAMPUS, or designee, approves the dental plan's procedures governing the itemization and completion of claims for services rendered by authorized providers to enrolled beneficiaries of the Active Duty Dependents Dental Plan consistent with the insurer's existing procedures for completion and submittal of dental claims for its other dental plans and accounts.

(6) *Reimbursement of authorized providers.* The Director, OCHAMPUS or designee, approves the dental plan methodology for reimbursement of services rendered by authorized providers consistent with law, regulation, and contract provisions, and the benefits of the Active Duty Dependents Dental Plan. The following general requirements for methodology shall be met, subject to modifications and exceptions approved by the Director, OCHAMPUS or a designee.

(i) Nonparticipating providers (or the dependents or sponsors for unassigned claims) shall be reimbursed at the equivalent of not less than the 50th percentile of prevailing charges made for similar services in the same locality (region) or state, or the provider's actual charge, whichever is lower; less any cost-share amount due for authorized services, except where the dental plan insurer is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days. In such instances of the nonavailability of a participating provider, the nonparticipating provider located within 35 miles of the dependent's place of residence shall be paid his or her usual fees, less the cost-share for the authorized services.

(ii) Participating providers shall be reimbursed at the equivalent of a percentile of prevailing charges sufficiently above the 50th percentile of prevailing charges made for similar services in the same locality (region) or state as to constitute a significant financial incentive for participation, or the provider's actual charge, whichever is lower; less any cost-share amount due for authorized services.

(g) *Benefit payment*—(1) *General.* Active Duty Dependent Dental Plan benefit payments are made either directly to the provider or to the beneficiary or sponsor, depending on the manner in which the claim is submitted or the terms of the subcontract of an alternative delivery system with the dental plan insurer.

(2) *Benefit payments made to a participating provider.* When the authorized provider has elected to participate in accordance with the arrangement and procedures established by the dental plan insurer, payment is made based on the lower of the actual charge or the

insurer's determination of the allowable charge. Payment is made directly to the participating provider as payment in full, less the percent cost-share of the insurer's allowable charge as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

(3) *Benefit payments made to a nonparticipating provider.* When the authorized provider has elected not to participate in accordance with the arrangement and procedures established by the dental plan, payment is made by the insurer based on the lower of the actual charge or the insurer's determination of the allowable charge. The beneficiary is responsible for payment of a percent cost-share of the insurer's allowable charge as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section. Where the dental plan is unable to identify a participating provider of care within 35 miles of the dependent's place of residence with appointment availability within 21 calendar days, dependents or their sponsors are responsible for payment of a percent cost-share of the charges made by nonparticipating providers located within 35 miles of the dependent's place of residence as specified in paragraphs (e)(3)(i) through (e)(3)(v) of this section.

(i) Assigned claims are claims submitted directly by the nonparticipating provider and are paid directly to the provider.

(ii) Nonassigned claims are claims submitted by the beneficiary, provider, or sponsor and are paid directly to the claimant.

(4) *Dental Explanation of Benefits (DEOB).* An explanation of benefits is sent to the beneficiary or sponsor and provides the following information:

(i) Name and address of the beneficiary.

(ii) Social Security Account Number (SSAN) of the sponsor.

(iii) Name and address of the provider.

(iv) Services or supplies covered by the claim for which the DEOB applies.

(v) Dates the services or supplies were provided.

(vi) Amount billed; allowable charge; and amount of payment.

(vii) To whom payment, if any, was made.

(viii) Reasons for any denial.

(ix) Recourse available to beneficiary for review of claim decision (refer to paragraph (h) of this section).

(5) *Fraud*—(i) *Federal laws.* 18 U.S.C. 287 and 1001 provide for criminal penalties for submitting knowingly or making any false, fictitious, or fraudulent statement or claim in any matter within the jurisdiction of any department or agency of the United States. Examples of fraud include situations in which ineligible persons not enrolled in the Active Duty Dependents Dental Plan obtain care and file claims for benefits under the name and identification of an enrolled beneficiary; or when providers submit claims for services and supplies not rendered to enrolled beneficiaries; or when a participating provider bills the beneficiary for amounts over the dental plan insurer's determination of allowable charges; or fails to collect the specified patient copayment amount.

(ii) *Suspected fraud.* Any person, including the dental plan insurer, who becomes aware of a suspected fraud shall report the circumstances in writing, together with copies of any available documents pertaining thereto, to the Director, OCHAMPUS, or a designee, who shall initiate an official investigation of the case.

(h) *Appeal and hearing procedures*—(1) *General.* This action sets forth the policies and procedures for appealing decisions made by the dental plan adversely affecting the rights and liabilities of beneficiaries, participating providers, and providers denied the status of authorized provider under the Active Duty Dependents Dental Plan. An appeal under the Active Duty Dependents Dental Plan is an administrative review of program determinations made under the provisions of law and regulation. An appeal cannot challenge the propriety, equity, or legality of any provision of law and regulation.

(i) *Initial determination*—(A) *Notice of initial determination and right to appeal.* (*1*) The dental plan contractor shall mail notices of initial determinations to the Active Duty Dependents Dental Plan beneficiary at the last known address. For beneficiaries who are under 18 years of age or who are incompetent,

a notice issued to the parent or guardian constitutes notice to the beneficiary.

(*2*) The dental plan contractor shall notify providers of an initial determination on a claim only if the providers participated in the claim or accepted assignment.

(*3*) Notice of an initial determination on a claim by the dental plan contractor shall be made in the contractor's explanation of benefits (beneficiary) or with the summary of payment (provider).

(*4*) Each notice of an initial determination on a request for benefit authorization, a request by a provider for approval as an authorized provider, or a decision to disqualify or exclude a provider, or a decision to disqualify or exclude a provider as an authorized provider under the Active Duty Dependents Dental Plan shall state the reason for the determination and the underlying facts supporting the determination.

(*5*) In any case when the initial determination is adverse to the beneficiary or participating provider or to the provider seeking approval as an authorized provider, the notice shall include a statement of the beneficiary's or provider's right to appeal the determination. The procedure for filing the appeal also shall be explained.

(B) *Effect of initial determination.* The initial determination is final, unless appealed in accordance with this section or unless the initial determination is reopened by OCHAMPUS or the dental plan contractor.

(ii) *Participation in an appeal.* Participation in an appeal is limited to any party to the initial determination, including OCHAMPUS, the dental plan contractor, and authorized representatives of the parties. Any party to the initial determination, except OCHAMPUS and the dental plan contractor, may appeal an adverse determination. The appealing party is the party who actually files the appeal.

(A) *Parties to the initial determination.* For purposes of these appeal and hearing procedures, the following are not parties to an initial determination and are not entitled to administrative review under this section.

(*1*) A provider disqualified or excluded as an authorized provider under the Active Duty Dependents Dental Plan based on a determination under another Federal or federally funded program is not a party to the OCHAMPUS action and may not appeal under this section

(*2*) A sponsor or parent of a beneficiary under 18 years of age or guardian of an incompetent beneficiary is not a party to the initial determination and may not serve as the appealing party, although such persons may represent the appealing party in an appeal.

(*3*) A third party other than the dental plan contractor, such as an insurance company, is not a party to the initial determination and is not entitled to appeal, even though it may have an indirect interest in the initial determination.

(*4*) A nonparticipating provider is not a party to the initial determination and may not appeal.

(B) *Representative.* Any party to the initial determination may appoint a representative to act on behalf of the party in connection with an appeal. Generally, the parent of a minor beneficiary and the legally appointed guardian of an incompetent beneficiary shall be presumed to have been appointed representative without specific designation by the beneficiary.

(*1*) The representative shall have the same authority as the party to the appeal, and notice given to the representative shall constitute notice required to be given to the party under this part.

(*2*) To avoid possible conflicts of interest, an officer or employee of the United States, such as an employee or member of a Uniformed Service, including an employee or staff member of a Uniformed Service legal office, or a OCHAMPUS advisor, subject to the exceptions in 18 U.S.C. 205, is not eligible to serve as a representative. An exception usually is made for an employee or member of a Uniformed Service who represents an immediate family member. In addition, the Director, OCHAMPUS, or designee, may appoint an officer or employee of the United States as the OCHAMPUS representative at a hearing.

(iii) *Burden of proof.* The burden of proof is on the appealing party to establish affirmatively by substantial evidence the appealing party's entitlement under law and this part to the authorization of the Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any cost or fee associated with the production or submission of information in support of an appeal may not be paid by OCHAMPUS.

(iv) *Late filing.* If a request for reconsideration, formal review, or hearing is filed after the time permitted in this section, written notice shall be issued denying the request. Late filing may be permitted only if the appealing party reasonably can demonstrate to the satisfaction of the dental plan contractor, or the Director, OCHAMPUS, or designee, that timely filing of the request was not feasible due to extraordinary circumstances over which the appealing party had no practical control. Each request for an exception to the filing requirement will be considered on its own merits.

(v) *Appealable issue.* An appealable issue is required in order for an adverse determination to be appealed under the provisions of this section. Examples of issues that are not appealable under this chapter include:

(A) A dispute regarding a requirement of the law or regulation.

(B) The amount of the dental plan contractor-determined allowable charge since the methodology constitutes a limitation on benefits under the provisions of this part.

(C) Certain other issues on the basis that the authority for the initial determination is not vested in OCHAMPUS. Such issues include but are not limited to the following examples:

(*1*) Determination of a person's eligibility as an enrolled beneficiary in the Active Duty Dependents Dental Plan is the responsibility of the appropriate Uniformed Service. Although OCHAMPUS and the dental plan contractor must make determinations concerning a beneficiary's enrollment, ultimate responsibility for resolving a beneficiary's eligibility and enrollment rests with the Uniformed Services. Accordingly, a disputed question of fact concerning a beneficiary's enrollment or eligibility will not be considered an appealable issue under the provisions of this section, but shall be resolved in accordance with paragraph (c) of this section.

(*2*) The decision to disqualify or exclude a provider because of a determination against that provider under another Federal or federally funded program is not an initial determination that is appealable under this part. The provider is limited to exhausting administrative appeal rights offered under the Federal or federally funded program that made the initial determination. However, a determination to disqualify or exclude a provider because of abuse or fraudulent practices or procedures under the Active Duty Dependents Dental Plan is an initial determination that is appealable under this part.

(vi) *Amount in dispute.* An amount in dispute is required for an adverse determination to be appealed under the provisions of this section, except as set forth in the following:

(A) The amount in dispute is calculated as the amount of money the dental plan contractor would pay if the services and supplies involved in dispute were determined to be authorized benefits of the Active Duty Dependents Dental Plan. Examples of amounts of money that are excluded by this part from payments for authorized benefits include, but are not limited to:

(*1*) Amounts in excess of the dental plan contractor-determined allowable charge.

(*2*) The beneficiary's cost-share amounts for restorative services.

(*3*) Amounts that the beneficiary, or parent, guardian, or other responsible person has no legal obligation to pay.

(B) There is no requirement for an amount in dispute when the appealable issue involves a denial of a provider's request for approval as an authorized provider or the determination to disqualify or exclude a provider as an authorized provider.

(C) Individual claims may be combined to meet the required amount in dispute if all of the following exist:

(*1*) The claims involve the same beneficiary.

(*2*) The claims involve the same issue.

(*3*) At least one of the claims so combined has had a reconsideration decision issued by the dental plan contractor.

NOTE: A request for administrative review under this appeal process which involves a dispute regarding a requirement of law or regulation (paragraph (h)(1)(v)(A) of this section) or does not involve a sufficient amount in dispute (paragraph (h)(1)(vi) of this section) may not be rejected at the reconsideration level of appeal. However, an appeal shall involve an appealable issue and sufficient amount in dispute under these subsections to be granted a formal review or hearing.

(vii) *Levels of appeal.* The sequence and procedures of an Active Duty Dependents Dental Plan appeal are contained in the following:

(A) Reconsideration by the dental plan contractor.

(B) Formal review by OCHAMPUS.

(C) Hearing.

(2) *Reconsideration.* Any party to the initial determination made by the dental plan contractor may request a reconsideration.

(i) *Requesting a reconsideration*—(A) *Written request required.* The request must be in writing, shall state the specific matter in dispute, and shall include a copy of the notice of initial determination made by the dental plan contractor, such as the explanation of benefits.

(B) *Where to file.* The request shall be submitted to the dental plan contractor's office as designated in the notice of initial determination.

(C) *Allowed time to file.* The request must be mailed within 90 days after the date of the notice of initial determination.

(D) *Official filing date.* A request for a reconsideration shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by the dental plan contractor.

(ii) *The reconsideration process.* The purpose of the reconsideration is to determine whether the initial determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested or at the time the provider requested approval as an authorized provider. The reconsideration is performed by a member of the dental plan contractor's staff who was not involved in making the initial determination and is a thorough and independent review of the case. The reconsideration is based on the information submitted that led to the initial determination, plus any additional information that the appealing party may submit or the dental plan contractor may obtain.

(iii) *Timeliness of reconsideration determination.* The dental plan contractor normally shall issue its reconsideration determination no later than 60 days from the date of its receipt of the request for reconsideration.

(iv) *Notice of reconsideration determination.* The dental plan contractor shall issue a written notice of the reconsideration determination to the appealing party at his or her last known address. The notice of the reconsideration determination must contain the following elements:

(A) A statement of the issue or issues under appeal.

(B) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(C) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(D) Whether the reconsideration upholds the initial determination or reverses it, in whole or in part, and the rationale for the action.

(E) A statement of the right to appeal further in any case when the reconsideration determination is less than fully favorable to the appealing party and the amount in dispute is $50 or more.

(v) *Effect of reconsideration determination.* The reconsideration determination is final if either of the following exist:

(A) The amount in dispute is less than $50.

(B) Appeal rights have been offered, but a request for formal review is not received by OCHAMPUS within 60 days of the date of the notice of the reconsideration determination.

(3) *Formal review.* Any party to the initial determination may request a formal review by OCHAMPUS if the party is dissatisfied with the reconsideration determination and the reconsideration determination is not final

under the provisions of paragraph (b)(5) of this section. Any party to the initial determination made by OCHAMPUS may request a formal review by OCHAMPUS if the party is dissatisfied with the initial determination.

(i) *Requesting a formal review*—(A) *Written request required.* The request must be in writing, shall state the specific matter in dispute, shall include copies of the written determination (notice of reconsideration determination) being appealed, and shall include any additional information or documents not submitted previously.

(B) *Where to file.* The request shall be submitted to the Chief, Appeals and Hearings, OCHAMPUS, Aurora, Colorado 80045–6900.

(C) *Allowed time to file.* The request shall be mailed within 60 days after the date of the notice of the reconsideration determination being appealed.

(D) *Official filing date.* A request for a formal review shall be deemed filed on the date it is mailed and postmarked. If the request does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

(ii) *The formal review process.* The purpose of the formal review is to determine whether the initial determination or reconsideration determination was made in accordance with law, regulation, policies, and guidelines in effect at the time the care was provided or requested, at the time the provider requested approval as an authorized provider, or at the time of the action by OCHAMPUS to disqualify or exclude a provider. The formal review is performed by the Chief, Appeals and Hearings, OCHAMPUS, or a designee, and is a thorough review of the case. The formal review determination shall be based on the information upon which the initial determination or reconsideration determination was based and any additional information the appealing party or the dental plan contractor may submit or OCHAMPUS may obtain.

(iii) *Timeliness of formal review determination.* The Chief, Appeals and Hearings, OCHAMPUS, or a designee, normally shall issue the formal review determination no late than 90 days from the date of receipt of the request for formal review by the OCHAMPUS.

(iv) *Notice of formal review determination.* The Chief, Appeals and Hearings, OCHAMPUS, or a designee, shall issue a written notice of the formal review determination to the appealing party at his or her last known address. The notice of the formal review determination must contain the following elements:

(A) A statement of the issue or issues under appeal.

(B) The provisions of law, regulation, policies, and guidelines that apply to the issue or issues under appeal.

(C) A discussion of the original and additional information that is relevant to the issue or issues under appeal.

(D) Whether the formal review upholds the prior determination or determinations or reverses the prior determination or determinations in whole or in part and the rationale for the action.

(E) A statement of the right to request a hearing in any case when the formal review determination is less than fully favorable, the issue is appealable, and the amount in dispute is $300 or more.

(v) *Effect of formal review determination.* The formal review determination is final if one or more of the following exist:

(A) The issue is not appealable. (See paragraph (1)(v) of this section.)

(B) The amount in dispute is less than $300. (See paragraph (h)(1)(vi) of this section.)

(C) Appeal rights have been offered, but a request for hearing is not received by OCHAMPUS within 60 days of the date of the notice of the formal review determination.

(4) *Hearing.* Any party to the initial determination may request a hearing if the party is dissatisfied with the formal review determination and the formal review determination is not final under the provisions of paragraph (c)(5) of this section.

(i) *Requesting a hearing*—(A) *Written request required.* The request shall be in writing, state the specific matter in dispute, include a copy of the formal review determination, and include any additional information or documents not submitted previously.

(B) *Where to file.* The request shall be submitted to the Chief, Appeals and

Hearings, OCHAMPUS, Aurora, Colorado 80045–6900.

(C) *Allowed time to file.* The request shall be mailed within 60 days after the date of the notice of the formal review determination being appealed.

(D) *Official filing date.* A request for hearing shall be deemed filed on the date it is mailed and postmarked. If a request for hearing does not have a postmark, it shall be deemed filed on the date received by OCHAMPUS.

(ii) *The hearing process.* The hearing shall be conducted as a nonadversary, administrative proceeding to determine the facts of the case and to allow the appealing party the opportunity personally to present the case before an impartial hearing officer. The hearing is a forum in which facts relevant to the case are presented and evaluated in relation to applicable law, regulation, policies, and guidelines in effect at the time the care was provided or requested, or at the time the provider requested approval as an authorized provider.

(iii) *Timeliness of hearing.* (A) Except as otherwise provided in this section, within 60 days following receipt of a request for hearing, the Director, OCHAMPUS, or a designee, normally will appoint a hearing officer to hear the appeal. Copies of all records in the possession of OCHAMPUS that are pertinent to the matter to be heard or that formed the basis of the formal review determination shall be provided to the hearing officer and, upon request, to the appealing party.

(B) The hearing officer, except as otherwise provided in this section, normally shall have 60 days from the date of written notice of assignment to review the file, schedule and hold the hearing, and issue a recommended decision to the Director, OCHAMPUS, or designee.

(C) The Director, OCHAMPUS, or designee, may delay the case assignment to the hearing officer if additional information is needed that cannot be obtained and included in the record within the time period specified above. The appealing party will be notified in writing of the delay resulting from the request for additional information. The Director, OCHAMPUS, or a designee, in such circumstances, will assign the case to a hearing officer within 30 days of receipt of all such additional information or within 60 days of receipt of the request for hearing, whichever shall occur last.

(D) The hearing officer may delay submitting the recommended decision if, at the close of the hearing, any party to the hearing requests that the record remain open for submission of additional information. In such circumstances, the hearing officer will have 30 days following receipt of all such additional information including comments from the other parties to the hearing concerning the additional information to submit the recommended decision to the Director, OCHAMPUS, or a designee.

(iv) *Representation at a hearing.* Any party to the hearing may appoint a representative to act on behalf of the party at the hearing, unless such person currently is disqualified or suspended from acting in another Federal administrative proceeding, or unless otherwise prohibited by law, this part, or any other DoD regulation (see paragraph (a)(2)(ii) of this section). A hearing officer may refuse to allow any person to represent a party at the hearing when such person engages in unethical, disruptive, or contemptuous conduct, or intentionally fails to comply with proper instructions or requests of the hearing officer or the provisions of this part. The representative shall have the same authority as the appealing party, and notice given to the representative shall constitute notice required to be given to the appealing party.

(v) *Consolidation of proceedings.* The Director, OCHAMPUS, or a designee, may consolidate any number of proceedings for hearing when the facts and circumstances are similar and no substantial right of an appealing party will be prejudiced.

(vi) *Authority of the hearing officer.* The hearing officer, in exercising the authority to conduct a hearing under this part, will be bound by 10 U.S.C., chapter 55 and this part. The hearing officer in addressing substantive, appealable issues shall be bound by the dental benefits brochure, policies, procedures, and other guidelines issued by the ASD(HA), or a designee, or by the Director, OCHAMPUS, or a designee, in

effect for the period in which the matter in dispute arose. A hearing officer may not establish or amend the dental benefits brochure, policy, procedures, instructions, or guidelines. However, the hearing officer may recommend reconsideration of the policy, procedures, instructions or guidelines by the ASD(HA), or a designee, when the final decision is issued in the case.

(vii) *Disqualification of hearing officer.* A hearing officer voluntarily shall disqualify himself or herself and withdraw from any proceeding in which the hearing officer cannot give fair or impartial hearing, or in which there is a conflict of interest. A party to the hearing may request the disqualification of a hearing officer by filing a statement detailing the reasons the party believes that a fair and impartial hearing cannot be given or that a conflict of interest exists. Such request immediately shall be sent by the appealing party or the hearing officer to the Director, OCHAMPUS, or a designee, who shall investigate the allegations and advise the complaining party of the decision in writing. A copy of such decision also shall be mailed to all other parties to the hearing. If the Director, OCHAMPUS, or a designee, reassigns the case to another hearing officer, no investigation shall be required.

(viii) *Notice and scheduling of hearing.* The hearing officer shall issue by certified mail, when practicable, a written notice to the parties to the hearing of the time and place for the hearing. Such notice shall be mailed at least 15 days before the scheduled date of the hearing. The notice shall contain sufficient information about the hearing procedure, including the party's right to representation, to allow for effective preparation. The notice also shall advise the appealing party of the right to request a copy of the record before the hearing. Additionally, the notice shall advise the appealing party of his or her responsibility to furnish the hearing officer, no later than 7 days before the scheduled date of the hearing, a list of all witnesses who will testify and a copy of all additional information to be presented at the hearing. The time and place of the hearing shall be determined by the hearing officer, who shall select a reasonable time and location mutually convenient to the appealing party and OCHAMPUS.

(ix) *Dismissal of request for hearing*—(A) *By application of appealing party.* A request for hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of the final decision, upon the application of the appealing party. A request for dismissal must be in writing and filed with the Chief, Appeals and Hearings, OCHAMPUS, or the hearing officer. When dismissal is requested, the formal review determination in the case shall be deemed final, unless the dismissal is vacated in accordance with paragraph (h)(4)(ix)(E) of this section.

(B) *By stipulation of the parties to the hearing.* A request for a hearing may be dismissed by the Director, OCHAMPUS, or a designee, at any time before the mailing of notice of the final decision under a stipulation agreement between the appealing party and OCHAMPUS. When dismissal is entered under a stipulation, the formal review decision shall be deemed final, unless the dismissal is vacated in accordance with paragraph (h)(4)(ix)(E) of this section.

(C) *By abandonment.* The Director, OCHAMPUS, or a designee, may dismiss a request for hearing upon abandonment by the appealing party.

(*1*) An appealing party shall be deemed to have abandoned a request for hearing, other than when personal appearance is waived in accordance with paragraph (h)(4)(xi)(m) of this section, if neither the appealing party nor an appointed representative appears at the time and place fixed for the hearing and if, within 10 days after the mailing of a notice by certified mail to the appealing party by the hearing officer to show cause, such party does not show good and sufficient cause for such failure to appear and failure to notify the hearing officer before the time fixed for hearing that an appearance could not be made.

(*2*) An appealing party shall be deemed to have abandoned a request for hearing if, before assignment of the case to the hearing officer, OCHAMPUS is unable to locate either the appealing party or an appointed representative.

(*3*) An appealing party shall be deemed to have abandoned a request for hearing if the appealing party fails to prosecute the appeal. Failure to prosecute the appeal includes, but is not limited to, an appealing party's failure to provide information reasonably requested by OCHAMPUS or the hearing officer for consideration in the appeal.

(*4*) If the Director, OCHAMPUS, or a designee, dismisses the request for hearing because of abandonment, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph (h)(4)(ix)(E) of this section.

(D) *For cause.* The Director, OCHAMPUS, or a designee, may dismiss for cause a request for hearing either entirely or as to any stated issue. If the Director, OCHAMPUS, or a designee, dismisses a hearing request for cause, the formal review determination in the case shall be deemed to be final, unless the dismissal is vacated in accordance with paragraph (h)(4)(ix)(E) of this section. A dismissal for cause may be issued under any of the following circumstances:

(*1*) When the appealing party requesting the hearing is not a proper party under paragraph (1)(ii)(A) of this section or does not otherwise have a right to participate in a hearing.

(*2*) When the appealing party who filed the hearing request dies, and there is no information before the Director, OCHAMPUS, or a designee, showing that a party to the initial determination who is not an appealing party may be prejudiced by the formal review determination.

(*3*) When the issue is not appealable (See paragraph (h)(1)(v) of this section.)

(*4*) When the amount in dispute is less than $300 (See paragraph (h)(1)(vi) of this section.)

(*5*) When all appealable issues have been resolved in favor of the appealing party.

(E) *Vacation of dismissal.* Dismissal of a request for hearing may be vacated by the Director, OCHAMPUS, or a designee, upon written request of the appealing party, if the request is received within 6 months of the date of the notice of dismissal mailed to the last known address of the party requesting the hearing.

(x) *Preparation for hearing*—(A) *Prehearing statement of contentions.* The hearing officer may on reasonable notice, require a party to the hearing to submit a written statement of contentions and reasons. The written statement shall be provided to all parties to the hearing before the hearing takes place.

(B) *Agency records*—(*1*) *Hearing officer.* A hearing officer may ask OCHAMPUS to produce, for inspection, any records or relevant portions of records when they are needed to decide the issues in any proceeding before the hearing officer or to assist an appealing party in preparing for the proceeding.

(*2*) *Appealing party.* A request to a hearing officer by an appealing party for disclosure or inspection of OCHAMPUS or the dental plan contractor records shall be in writing and shall state clearly what information and records are required.

(C) *Witnesses and evidence.* All parties to a hearing are responsible for producing, at each party's expense, meaning without reimbursement of payment by OCHAMPUS, witnesses and other evidence in their own behalf, and for furnishing copies of any such documentary evidence to the hearing officer and other party or parties to the hearing. The Department of Defense is not authorized to subpoena witnesses or records. The hearing officer may issue invitations and requests to individuals to appear and testify without cost to the Government, so that the full facts in the case may be presented.

(D) *Interrogatories and depositions.* A hearing officer may arrange to take interrogatories and depositions, recognizing that the Department of Defense does not have subpoena authority. The expense shall be assessed to the requesting party, with copies furnished to the hearing officer and other party or parties to the hearing.

(xi) *Conduct of hearing*—(A) *Right to open hearing.* Because of the personal nature of the matters to be considered, hearings normally shall be closed to the public. However, the appealing party may request an open hearing. If this occurs, the hearing shall be open,

except when protection of other legitimate Government purposes dictates closing certain portions of the hearing.

(B) *Right to examine parties to the hearing and their witnesses.* Each party to the hearing shall have the right to produce and examine witnesses, to introduce exhibits, to question opposing witnesses on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party to the hearing first called the witness to testify, and to rebut any evidence presented. Except for those witnesses employed by OCHAMPUS at the time of the hearing or records in the possession of OCHAMPUS, a party to a hearing shall be responsible, that is to say no payment or reimbursement shall be made by CHAMPUS for the cost or fee associated with producing witnesses or other evidence in the party's own behalf, or for furnishing copies of documentary evidence to the hearing officer and other party or parties to the hearing.

(C) *Burden of proof.* The burden of proof is on the appealing party affirmatively to establish by substantial evidence the appealing party's entitlement under law and this Regulation to the authorization of Active Duty Dependents Dental Plan benefits or approval as an authorized provider. Any part of the cost or fee associated with producing or submitting in support of an appeal may not be paid by OCHAMPUS.

(D) *Taking of evidence.* The hearing officer shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties to the hearing. Before taking evidence, the hearing officer shall identify and state the issues in dispute on the record and the order in which evidence will be received.

(E) *Questioning and admission of evidence.* A hearing officer may question any witness and shall admit any relevant evidence. Evidence that is irrelevant or unduly repetitious shall be excluded.

(F) *Relevant evidence.* Any relevant evidence shall be admitted, unless unduly repetitious, if it is the type of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule that might make improper the admission of such evidence over objection in civil or criminal actions.

(G) *Active Duty Dependents Dental Plan determination first.* The basis of the Active Duty Dependents Dental Plan determinations shall be presented to the hearing officer first. The appealing party shall then be given the opportunity to establish affirmatively why this determination is held to be in error.

(H) *Testimony.* Testimony shall be taken only on oath, affirmation, or penalty of perjury.

(I) *Oral argument and briefs.* At the request of any party to the hearing made before the close of the hearing, the hearing officer shall grant oral argument. If written argument is requested, it shall be granted, and the parties to the hearing shall be advised as to the time and manner within which such argument is to be filed. The hearing officer may require any party to the hearing to submit written memoranda pertaining to any or all issues raised in the hearing.

(J) *Continuance of hearing.* A hearing officer may continue a hearing to another time or place on his or her own motion or, upon showing of good cause, at the request of any party. Written notice of the time and place of the continued hearing, except as otherwise provided here, shall be in accordance with this part. When a continuance is ordered during a hearing, oral notice of the time and place of the continued hearing may be given to each party to the hearing who is present at the hearing.

(K) *Continuance for additional evidence.* If the hearing officer determines, after a hearing has begun, that additional evidence is necessary for the proper determination of the case, the following procedures may be invoked:

(*1*) *Continue hearing.* The hearing may be continued to a later date in accordance with paragraph (d)(11)(x) of this section.

(*2*) *Closed hearing.* The hearing may be closed, but the record held open in order to permit the introduction of additional evidence. Any evidence submitted after the close of the hearing

shall be made available to all parties to the hearing, and all parties to the hearing shall have the opportunity for comment. The hearing officer may reopen the hearing if any portion of the additional evidence makes further hearing desirable. Notice thereof shall be given in accordance with paragraph (d)(8) of this section.

(L) *Transcript of hearing.* A verbatim taped record of the hearing shall be made and shall become a permanent part of the record. Upon request, the appealing party shall be furnished a duplicate copy of the tape. A typed transcript of the testimony will be made only when determined to be necessary by OCHAMPUS. If a typed transcript is made, the appealing party shall be furnished a copy without charge. Corrections shall be allowed in the typed transcript by the hearing officer solely for the purpose of conforming the transcript to the actual testimony.

(M) *Waiver of right to appear and present evidence.* If all parties waive their right to appear before the hearing officer for presenting evidence and contentions personally or by representation, it will not be necessary for the hearing officer to give notice of, or to conduct a formal hearing. A waiver of the right to appear must be in writing and filed with the hearing officer or the Chief, Appeals and Hearings, OCHAMPUS. Such waiver may be withdrawn by the party by written notice received by the hearing officer or Chief, Appeals and Hearings, no later than 7 days before the scheduled hearing or the mailing of notice of the final decision, whichever occurs first. For purposes of this section, failure of a party to appear personally or by representation after filing written notice of waiver, will not be cause for finding of abandonment and the hearing officer shall make the recommended decision on the basis of all evidence of record.

(N) *Recommended decision.* At the conclusion of the hearing and after the record has been closed, the matter shall be taken under consideration by the hearing officer. Within the time frames previously set forth in this section, the hearing officer shall submit to the Director, OCHAMPUS, or a designee, a written recommended decision containing a statement of findings and a statement of reasons based on the evidence adduced at the hearing and otherwise included in the hearing record.

(*1*) *Statement of findings.* A statement of findings is a clear and concise statement of fact evidenced in the record or conclusions that readily can be deduced from the evidence of record. Each finding must be supported by substantial evidence that is defined as such evidence as a reasonable mind can accept as adequate to support a conclusion.

(*2*) *Statement of reasons.* A reason is a clear and concise statement of law, regulation, policies, or guidelines relating to the statement of findings that provides the basis for the recommended decision.

(5) *Final decision*—(i) *Director, OCHAMPUS.* The recommended decision shall be reviewed by the Director, OCHAMPUS, or a designee, who shall adopt or reject the recommended decision or refer the recommended decision for review by the Assistant Secretary of Defense (Health Affairs). The Director, OCHAMPUS, or designee, normally will take action with regard to the recommended decision within 90 days of receipt of the recommended decision or receipt of the revised recommended decision following a remand order to the Hearing Officer.

(A) *Final action.* If the Director, OCHAMPUS, or a designee, concurs in the recommended decision, no further agency action is required and the recommended decision, as adopted by the Director, OCHAMPUS, is the final agency decision in the appeal. In the case of rejection, the Director, OCHAMPUS, or a designee, shall state the reason for disagreement with the recommended decision and the underlying facts supporting such disagreement. In these circumstances, the Director, OCHAMPUS, or a designee, may have a final decision prepared based on the record, or may remand the matter to the Hearing Officer for appropriate action. In the latter instance, the Hearing Officer shall take appropriate action and submit a new recommended decision within 60 days of receipt of the

remand order. The decision by the Director, OCHAMPUS, or a designee, concerning a case arising under the procedures of this section, shall be the final agency decision and the final decision shall be sent by certified mail to the appealing party or parties. A final agency decision under this paragraph (h)(5)(i) will not be relied on, used, or cited as precedent by the Department of Defense or the dental plan contractor in the administration of the Active Duty Dependents Dental Plan.

(B) *Referral for review by ASD(HA).* The Director, OCHAMPUS, or a designee, may refer a hearing case to the Assistant Secretary of Defense (Health Affairs) when the hearing involves the resolution of policy and issuance of a final decision which may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan. In such a circumstance, the Director, OCHAMPUS, or a designee, shall forward the recommended decision, together with the recommendation of the Director, OCHAMPUS, or a designee, regarding disposition of the hearing case.

(ii) *ASD(HA).* The ASD(HA), or a designee, after reviewing a case arising under the procedures of this section may issue a final decision based on the record in the hearing case or remand the case to the Director, OCHAMPUS, or a designee, for appropriate action. A decision issued by the ASD(HA), or a designee, shall be the final agency decision in the appeal and a copy of the final decision shall be sent by certified mail to the appealing party or parties. A final decision of the ASD(HA), or a designee, issued under this paragraph (h)(5)(ii) may be relied on, used, or cited as precedent in the administration of the Active Duty Dependents Dental Plan.

(i) *Extension of the Active Duty Dependents' Dental Plan to areas outside the United States.* The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) may, under the authority of 10 U.S.C. 1076a(h), extend the Active Duty Dependents' Dental Plan to areas other than those areas specified in paragraph(a)(2)(i) of this section for the eligible dependents of members of the uniformed services accompanying the members on permanent assignment to duty in such areas. Action by the ASD(HA) to extend the program to any such area shall be announced through the publication of a notice in the FEDERAL REGISTER. In extending the program outside the United States, the ASD(HA) is authorized to establish program elements, methods of administration and payment rates to providers that are different from those in effect under this section in the United States to the extent the ASD(HA) determines necessary for the effective and efficient operation of the plan outside the United States. One such difference is that in areas other than those areas specified in paragraph (a)(2)(i) of this section, services under the active duty dependents' dental plan must be preauthorized by a designated DOD official, who may deny preauthorization if the needed services are available in a dental treatment facility of the Department of Defense. Other differences may occur based on limitations in the availability and capabilities of that nation's civilian sector providers in certain areas. Another difference is that a waiver of the annual maximum coverage amount for non-orthodontic dental benefits or the lifetime maximum coverage amount for orthodontics is authorized based on extraordinary circumstances governing the cost of dental services in a particular geographic area. Otherwise, rules pertaining to services covered under the plan, beneficiary cost sharing and quality of care standards for providers shall be comparable to those in effect under this section in the United States. In addition, all provisions of 10 U.S.C. 1076a shall remain in effect.

[53 FR 2020, Jan. 26, 1988, as amended at 55 FR 43342, Nov. 16, 1990; 60 FR 55451, Nov. 1, 1995; 62 FR 39941, July 25, 1997]

§ 199.14 Provider reimbursement methods.

(a) *Hospitals.* The CHAMPUS-determined allowable cost for reimbursement of a hospital shall be determined on the basis of one of the following methodologies.

(1) *CHAMPUS Diagnosis Related Group (DRG)-based payment system.* Under the CHAMPUS DRG-based payment system, payment for the operating costs of inpatient hospital services furnished